APPLICATION FOR PODIATRY LICENSE

State Form 27521 (R9 / 11-02)

Approved by State Board of Accounts, 2002

* Social Security number is required pursuant to I. C. 4-1-8-1.

Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, IN 46204
Telephone Number: (317) 232-2960

OFFICE USE ONLY	
License / Exam fee	Date fee paid *(month, day, year)*
Receipt number	License number
License issuance date *(month, day, year)*	

Applicant

Attach two (2) passport type quality photographs of yourself taken within the last eight weeks.
Please sign each photo at the bottom.
Negative and Polaroids are not acceptable.

APPLICANT INFORMATION		
Name of applicant *(last, first, middle)*	* Social Security number	
Address *(number and street or Rural Route number)*		
City, state, ZIP code		
Daytime telephone number ( )	Evening telephone number ( )	Email address
Date of birth *(month, day, year)*	Place of birth	

BASIS FOR LICENSURE

BASIS FOR LICENSURE PLEASE CHECK ONE BOX BELOW

☐ Examination

You are applying to take the PMLEXIS exam in Indiana.

☐ Endorsement of Examination

You have passed the PMLEXIS exam, you meet all other requirements for examination but you have not practiced podiatry for at least five (5) years in another state.

☐ Endorsement

You have passed the PMLEXIS exam, you meet all other requirements for examination and you have practiced podiatry for at least five (5) years in another state.

Do you desire a temporary permit?

☐ Yes ☐ No

Name of malpractice insurance carrier:

PRE-PROFESSIONAL EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED

PODIATRIC EDUCATION			
YEAR	NAME OF SCHOOL	LOCATION	DATES ATTENDED
1st			
2nd			
3rd			
4th			
5th			

PODIATRIC DEGREE GRANTED BY		
Name of school	Location	Date of graduation

*List all Postgraduate Training, include **all** Preceptorships, Residencies and Fellowships.*

NAME OF HOSPITAL	LOCATION	DATES: FROM TO *(month / year)*

Do you hold or have you ever held a license, certificate, registration or permit to practice any regulated health occupations?

☐ Yes ☐ No

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	STATE	CURRENT STATUS

List all places of employment since graduation. Endorsement candidates must submit proof of at least five years of employment.

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE

List all places you have lived since graduation.

GENERAL LOCATION	DATE

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, include the violation, location, date and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registraton or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice podiatric medicine or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No

3. Are you now, or have you ever been, treated for a drug abuse or alcohol problem? ☐ Yes ☐ No

4. Have you ever been charged with drug addiction? ☐ Yes ☐ No

5. Have you ever been convicted of, pled guilty or *nolo contendere* to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug additions? ☐ Yes ☐ No
   B. Any offense, misdemeaner or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ Yes ☐ No

6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No

7. Have you ever been admonished, censored, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privilieges or acted as a consultant? ☐ Yes ☐ No

8. Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties or perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any or its authorized representatives in connection with processing my application for podiatric licensure.
I herby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my applicaton, and I hereby specifically release the Bureau and the Commitee from any and all liability in connection with such disclosures.

A photostatic copy or this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date *(month, day, year)*